

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012229</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/09/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT JUDAY CREEK LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6330 N FIR RD</b> <b>GRANGER, IN 46530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00132067.</p> <p>Complaint IN00132067 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 8-9, 2013</p> <p>Facility number: 012229 Provider number: 012229 AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: Residential: 111 Total: 111</p> <p>Census payor type: Other: 111 Total: 111</p> <p>Sample: 3</p> <p>Hearth at Juday Creek was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00132067.</p> <p>Quality Review 07/10/13 by Lisa McColly</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

IM2Z11

If continuation sheet 1 of 1